RESOLVING THE CAUSE OF PAIN

Vaginismus is characterised by difficulty with vaginal penetration and involuntary muscle contraction, whereas pain is the main diagnostic criteria for dyspareunia.

A high index of suspicion may assist in the detection and resolution of pain often suffered silently.

DYSpareunia is a common and distressing female sexual condition that remains under-reported and under-treated.

Female sexual dysfunction is highly prevalent (11%) and is associated with a negative impact on physical, psychological and overall quality of life.

This article provides an overview of dyspareunia and uses a typical case study to illustrate the benefits of a physiotherapeutic approach.

CAUSATION

Vaginismus and dyspareunia are often co-occurring and difficult to differentiate.

A high index of suspicion may assist in the detection and resolution of pain often suffered silently.

Analysis of the literature indicates that dyspareunia and Vaginismus are frequently misdiagnosed and under-treated. Dyspareunia is highly prevalent (11%) and is associated with a negative impact on physical, psychological and overall quality of life.

This article provides an overview of dyspareunia and uses a typical case study to illustrate the benefits of a physiotherapeutic approach.

CAUSATION

Vaginismus and dyspareunia are often co-occurring and difficult to differentiate.

Diagnosis: Isabelle was referred for physiotherapy following a normal trans-abdominal pelvic ultrasound. She was unable to tolerate a trans-vaginal approach.

Assessment: Initial assessment involved patient education of pelvic anatomy, particularly pelvic floor muscles and discussion of the causes of vaginal pain.

With consent, a vaginal palpation of the pelvic floor muscles was performed to find vaginismus in the levator ani muscles, particularly on the left.

Treatment: Isabelle commenced a program including myofascial release and trigger point therapy by her physiotherapist as well as down-training (relaxation) exercises.

She was encouraged to avoid penetrative intercourse during treatment but to continue other forms of intimacy. Treatment also included the use of vaginal trainer cylinders (dilators), biofeedback and sexual education focusing on arousal.

After six treatments, Isabelle was encouraged to recommence intercourse after using her largest trainer and with appropriate lubricant (e.g. Sylk or olive oil) when she was pain free. She was discharged from physiotherapy with a maintenance pelvic floor program.

HIDDEN HURDLES

Treatment barriers include: unresolved vulval skin conditions, mental health issues, PTSD related to past trauma, relationship difficulties and difficulty engaging with the program (goals unmet by the patient), and inability to prioritise self-treatment.

It is important for GPs to be aware that women are often reluctant to mention dyspareunia.

There is, therefore, a need for an increased level of suspicion.

Indications include pain during routine vaginal examination or Pap smear.

If vaginismus is suspected or palpated, it usually requires physiotherapy treatment.